[Reported for the COLLEGE AND CLINICAL RECORD.]

Clinical Lectures.

JEFFERSON MEDICAL COLLEGE HOSPITAL.

GYNÆCOLOGICAL CLINIC, HELD MARCH 14TH, 1883, BY J. EWING MEARS, M. D.,

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CASE I.—VESICO-VAGINAL FISTULA, WITH REMARKS.
CASE II.—EPITHELIOMA OF VULVA; OPERATION.

GENTLEMEN:—I will give you a short account of a case, and then have it brought before you for examination.

Mrs. X, about fifty years of age, married, has been troubled for nearly twenty-five years with inability to retain her urine; in fact, she complains that it is constantly dribbling from her, keeping her in an uncomfortable, disagreeable condition, which makes her shun society, and renders her offensive to herself. She attributes this to a difficult labor with her last child; she was several days in labor; the child's head was large, and after delivery she had a poor getting up, and was obliged to remain in bed for several weeks.

I examined the patient, and found that she has an abnormal opening between the vagina and bladder, what is technically called a vesico-vaginal fistula. The ordinary causes of this condition after labor are (1) prolonged pressure of the child's head in parturition, which contuses the soft parts and is followed by sloughing; and (2) the improper application of the forceps, the blades being forced together before they are in proper position; they may thus actually pinch off a portion of the anterior wall of the vagina, or, if not entirely cut out at the time, it may be so bruised and crushed as to lead to sloughing. Vesico-vaginal fistulæ may also occur as the result of other injuries; a woman may fall astride a fence, or a chair, forcing a sharp piece of wood or similar substance into the vagina, so as to lacerate the anterior wall, thus producing a large wound and loss of substance, and establishing a communication with the base of the bladder, which remains constantly open. These different forms of injury just mentioned are the principal causes of this disorder. You may also find, in malignant disease of the uterus or vagina, that a communication by one or more openings may be established by ulceration into the bladder, but these form a separate class. Another, and a rare cause of vesico-vaginal fistula is the occurrence of inflammation followed by suppuration in the peritoneal or pelvic cavity; the pus being discharged into the bladder, or, working its way downward between them, establishes openings both in the vagina and bladder. A case of this kind was before the clinic not very long ago, where the pus from the pelvic abscess found its way first into the bladder, and subsequently into the vagina.

These fistulous openings differ in their position, and also in size. For instance, they may occur in the urethra, forming a urethro-vaginal fistula; or they may be at any part of the anterior vaginal wall, or even higher up, and the urine may be discharged into the uterine cavity, forming a utero-vesical fistula, or into both cervical and vaginal canals, forming a utero-vesico-vaginal fistula. Therefore, as regards the location of the openings, they may vary very much. They also differ greatly in size. They may be so small as a pin's point, or only admitting the smallest probe, or they may pass entirely across the vagina. In some cases of prolonged pressure during the descent of the head there is sloughing of the entire anterior wall of the vagina, leaving a large opening, nearly oval in shape, involving the loss of almost the entire base of the bladder.

You can readily understand that a woman in this condition suffers great inconvenience. This good woman states that she suffered more formerly than she does now. I think that this is due to the fact that the parts have, in a measure, accommodated themselves to her changed condition; the muscular tissue of the lower part of the vagina has become contracted, so that she can to a certain extent restrain her flow of water. We sometimes see prolapse of the bladder through the fistulous opening; in which case it has to be pushed back again, and means adopted to keep it in position. Cases have been reported, in which almost the entire bladder has been forced through into the vaginal tube, appearing as a large tumor-like mass between the labia. In such cases there is always more or less loss of tone in the vaginal muscular tissue also.

As to treatment, it may be (1) palliative or (2) radical. By palliative treatment, we merely aim to make the patient comfortable and relieve her of some of the annoyance from the incontinence of urine. This may be done by the use of a urinal made of rubber, which is to be constantly worn during the day. Of course, it is some inconvenience to wear such an apparatus, but it is better than to submit to the constant flow of urine. Poor patients, unable to purchase such an apparatus, sometimes make their condition more tolerable by plugging the vagina with a cloth, which makes pressure upon the openings and to some extent succeeds in stopping the escape of the urine This plan has been adopted by this patient, with some relief. Our patient also informs me that since this

fistula was formed she has not passed a drop of urine by the urethra; all has been passed through the opening into the vagina.

The *radical* treatment consists in a plastic surgical operation for the closure of this fistulous tract. The whole world is indebted to a graduate of this school, Dr. J. Marion Sims, of New York, formerly of Georgia, for his systematized method of operating in these cases, which has been attended with great success, and for his speculum, for aid in exposing the field of operation. To Dr. N. R. Bozeman, of New York, we are likewise greatly indebted for his silver-wire suture, which is fastened by the application of perforated shot. In the operation the borders of the wound are carefully pared with the scissors, the edges accurately approximated and fastened in position with the interrupted wire suture, clamped with perforated shot. A self-retaining catheter is then introduced into the urethra, and the woman is put to bed; the urine flowing out through the catheter does not collect in the bladder, and hence the wound may become completely united.

The description of this operation makes it seem like a very simple one, but, on the contrary, there is none in surgery that so often fails. Repeated operations are required to close some of the smallest openings. In one case, which I had the honor to see with an eminent surgeon of this city, I assisted in ten operations before the fistula was permanently closed. The tenth operation succeeded; the others all failed.

You should always tell your patients, before performing the operation, that it may not be completely successful, and may have to be repeated, or you may be blamed for want of skill or proper care. The first operation frequently fails to secure closure of the entire opening, but it may be able to close it in part. I think, therefore, that no prudent surgeon will positively promise a patient entire success from the first operation. You can understand the difficulties to be met; in the first place, you have a cavity or sac into which urine constantly flows, and which may come in contact with the edges of the wound. Then there is the disadvantage in operating in the depth of the vaginal tube. Moreover, the opening may be so small that you can scarcely find it. You only know it exists by the constant oozing of the urine through a pin-sized opening, through which it continues to leak in spite of repeated operations.

[The patient, in the knee-elbow posture upon a bed, and enveloped in a sheet, was now brought into the amphitheatre.]

The position in which this patient has been placed is the best one for exposing the field for examination and operation. You observe that she has a cloth placed in the lower part of the vagina, so that the water may not escape from the bladder and wet her clothing. We notice about this woman a heavy urinous odor, due to the oozing, and you also observe that the vulva is excoriated by the urine, which makes her condition a very disagreeable one. Now, on attempting to introduce a Sims speculum, you see that there is considerable contraction of the vaginal orifice; she has learned to contract this sphincter muscle so as to retain the cloth in position, and protect herself from the flow of urine.

I find that the fistulous opening into the bladder is high up, near the neck of the uterus. The opening is so high up, in fact, that I can scarcely reach it with the tip of my finger. I find that it is large enough to admit the end of my index finger, which readily passes into the vesical cavity and encounters the sound which I introduce through the urethra. There is in this case contraction and thickening of the walls of the bladder, as a necessary result of this condition.

This contraction is apt to follow any permanent opening into the bladder. Now you are probably aware that one form of treatment of chronic cystitis in the female is by making an incision into the base of the bladder and introducing a glass button, to keep the wound permanently open. As a result of this there is always contraction of the bladder, its walls contracting down upon the opening, becoming thickened, diminishing its cavity, and permanently reducing its capacity. This is the great objection to the operation. A similar condition exists here, and it is one reason why it is so difficult to obtain satisfactory results after operation. As she is not prepared to stay here she will have to return for operation at a subsequent clinic.

EPITHELIOMA OF THE VULVA—EXCISION.

The next case upon which I propose to operate is one of malignant disease of the vulva; the operation will require the removal of the left labium and the greatest portion of the right, with part of the mons veneris. It is a case similar to one which was before the class a few days ago. She gives the following history:—

Mary E., 58 years of age, married, has had five children, the youngest being thirty years old. Her parents both died with phthisis. She has had symptoms of the disease for about a year; it began with itching and burning, especially after passing urine, which existed for some time before any ulcer was observed.

She has not suffered any pain, and in this respect her case is an exception to the general rule; the epithelioma is generally the site of lancinating or burning pain. There is no history of any local injury nor of specific disease. The surface began to be raw about eight months ago; a swelling was first noticed five months ago. She has had medical treatment for the condition, but without success.

The patient is now thoroughly etherized, and is brought to the edge of the table, in the lithotomy position, on her back, with the knees and thighs flexed, and so held by assistants. You observe this malignant mass which occupies the left larger labium. It appears to be confined to the labium major; the labium minor is not involved. A careful examination, made yesterday, showed that it is outside of the nympha. On the right side there is a swelling or tumor in the labium major also; it is not involved in the original disease, but it may be a secondary growth. The mons veneris is also not directly affected. We were very glad to find also that the urethra is not involved; the mass is outside the nympha, and consequently some distance away from the urethra. Recalling the anatomy of the part, the labia minora diverging below the clitoris, to pass on each side of the vestibule, it is evident that disease located outside of the nymphæ will not involve the urethra.

The forms of malignant disease that may attack the vulva are various; sometimes encephaloid, scirrhus, or sarcoma is seen, but epithelioma is the most frequently encountered. The latter begins at the muco-cutaneous juncture; it seems to especially select those places where skin changes into mucous membrane, just as in this case, where the disease appeared at the place where the labium turns into the nympha. It probably commenced as a fissure or crack; when she first noticed it, she says that it was already the size of a ten-cent piece.

The only treatment to be adopted is excision and removal of the entire mass. For this reason the disease should be treated at as early a stage as possible, and not delayed too long, as the surrounding structures will become infiltrated. I will proceed to do this now, and after removing all the invaded structures, I will draw the wound together so as not to leave a large, raw surface. There will be considerable hemorrhage. The parts, as you know, are very vascular, and have the same relative blood supply as in the male sexual organs—the corpus spongiosum of the penis is represented by the bulbi-vestibuli and pars intermedia with its bulbar arteries; the corpora cavernosa and cavernous arteries of the penis likewise by those of the clitoris, which is also provided with its dorsal arteries, representing similar branches of the internal pudic artery in the male.

In order to guard against serious hemorrhage I have ligatures convenient, and also hot water. I have also some styptics, but prefer not to resort to them if it be at all possible to avoid it, as I do not wish to interfere with repair. I will use the hot water if there is much oozing, and if it is not then checked will make pressure with a T bandage. I will not stop to tie the vessels during the operation, but will compress them with the spring until I have removed the mass.

The parts are shaved prior to operation, and I have introduced a sound into the urethra, in order to keep it out of the way; this is a point of decided importance. A rather large knife or bistoury is needed, which is carried around the mass at some distance from the disease. The labium is grasped with a volsella, by an assistant, and lifted out of the way, while I continue the incision. I will extend the wound so as to include the nodule in the right labium, to which I called your attention. This is the large mass, having on its surface the epitheliomatous ulcer; here is the nodule on the right side, which seems to be cystic in character. The wound is a large one, and there are several small arteries which are bleeding, to which I will now apply ligatures. The surface is next syringed with hot water, to check oozing, and I will now bring the edges together with several points of the interrupted suture. A catheter will be used to empty the bladder, for a few days, and she will receive anodynes and other remedies which may be rerequired by her condition.

[The case was doing well at the last report, union taking place largely by first intention.—REP.]

HOSPITAL OF THE UNIVERSITY OF PENNSYLVANIA.

A CLINICAL LECTURE, DELIVERED NOV. 1, 1882,
BY WILLIAM GOODELL, M.D.,
(Class of 1854, J. M. C.)

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CANCER OF THE CERVIX UTERI TREATED BY SCRAPING—RECOVERY.*

GENTLEMEN—The history of this case alone will, I think, enable you to make the diagnosis. It is as follows: She is forty-two years of age, has had eight children, the youngest of which is two years of age. She has done her duty to the commonwealth, and in these days, when there is often but one child in twenty years, a woman who has had eight children is worthy of a civic crown. Her labors were so

* From the *Buffalo Medical and Surgical Journal*, Feb., 1883.